

		FOR OHF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0043398</u> Facility Name: <u>BURNHAM HEALTHCARE</u> Address: <u>14500 S. MANISTEE</u> <u>BURNHAM</u> <u>60633</u> <div style="display: flex; justify-content: space-around; width: 100%;"> Number City Zip Code </div> County: <u>COOK</u> Telephone Number: <u>(708) 862-1200</u> Fax # <u>(708) 862-1263</u> IDPA ID Number: <u>36-4205217</u> Date of Initial License for Current Owners: <u>03/01/98</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>	
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In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>103</u>	Skilled (SNF)	<u>103</u>	<u>37,698</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>206</u>	Intermediate (ICF)	<u>206</u>	<u>75,396</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>309</u>	TOTALS	<u>309</u>	<u>113,094</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF		<u>1,934</u>	<u>8,577</u>	<u>10,511</u>	8
9	SNF/PED					9
10	ICF	<u>101,507</u>			<u>101,507</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>101,507</u>	<u>1,934</u>	<u>8,577</u>	<u>112,018</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 99.05%)D. How many bed-hold days during this year were paid by Public Aid?
_____ (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 03/01/98J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 03/01/98 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 23 and days of care provided 8354

Medicare Intermediary _____

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2000 Ending: 12/31/2000
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	246,826	33,572	18,935	299,333		299,333	0	299,333		1
2	Food Purchase		364,588		364,588		364,588	0	364,588		2
3	Housekeeping	206,391	35,313	0	241,704		241,704	0	241,704		3
4	Laundry	116,355	32,823	4,285	153,463		153,463	0	153,463		4
5	Heat and Other Utilities			152,668	152,668		152,668	149	152,817		5
6	Maintenance	144,099	52,660	51,929	248,688		248,688	7,473	256,161		6
7	Other (specify):*			22,629	22,629		22,629	0	22,629		7
8	TOTAL General Services	713,671	518,956	250,446	1,483,073		1,483,073	7,622	1,490,695		8
	B. Health Care and Programs										
9	Medical Director			7,000	7,000		7,000	0	7,000		9
10	Nursing and Medical Records	2,979,300	122,928	43,785	3,146,013		3,146,013	2,515	3,148,528		10
10a	Therapy	0	11,404	4,250	15,654		15,654	0	15,654		10a
11	Activities	109,812	15,094	3,900	128,806		128,806	0	128,806		11
12	Social Services	165,752		3,725	169,477		169,477	0	169,477		12
13	Nurse Aide Training			6,354	6,354		6,354	0	6,354		13
14	Program Transportation			3,420	3,420		3,420	0	3,420		14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	3,254,864	149,426	72,434	3,476,724		3,476,724	2,515	3,479,239		16
	C. General Administration										
17	Administrative	133,637		670,000	803,637		803,637	(536,416)	267,221		17
18	Directors Fees			0				0			18
19	Professional Services			60,863	60,863		60,863	32,280	93,143		19
20	Dues, Fees, Subscriptions & Promotions			21,753	21,753		21,753	(2,442)	19,311		20
21	Clerical & General Office Expense	211,372	34,483	222,256	468,111		468,111	(6,072)	462,039		21
22	Employee Benefits & Payroll Taxes			726,847	726,847		726,847	0	726,847		22
23	Inservice Training & Education			4,239	4,239		4,239	164	4,403		23
24	Travel and Seminar			0				0			24
25	Other Admin. Staff Transportation			41,401	41,401		41,401	1,291	42,692		25
26	Insurance-Prop.Liab.Malpractice			110,000	110,000		110,000	3,026	113,026		26
27	Other (specify):*			0				19,005	19,005		27
28	TOTAL General Administration	345,009	34,483	1,857,359	2,236,851		2,236,851	(489,164)	1,747,687		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,313,544	702,865	2,180,239	7,196,648		7,196,648	(479,027)	6,717,621		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			601,438	601,438		601,438	(121,787)	479,651		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			1,351,433	1,351,433		1,351,433	(3,551)	1,347,882		32
33	Real Estate Taxes			639,322	639,322		639,322	2,829	642,151		33
34	Rent-Facility & Grounds			17,798	17,798		17,798	(17,798)			34
35	Rent-Equipment & Vehicles			37,937	37,937		37,937	10,650	48,587		35
36	Other (specify):* amort.-comp. soft.			27,674	27,674		27,674	0	27,674		36
37	TOTAL Ownership			2,675,602	2,675,602		2,675,602	(129,657)	2,545,945		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers			472,721	472,721		472,721	0	472,721		39
40	Barber and Beauty Shops							0			40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			183,547	183,547		183,547	0	183,547		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers			656,268	656,268		656,268		656,268		44
45	GRAND TOTAL COST										
	(sum of lines 29, 37 & 44)	4,313,544	702,865	5,512,109	10,528,518	0	10,528,518	(608,684)	9,919,834		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398

Report Period Beginning: **01/01/2000**

Ending: **2/31/2000**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(125,029)	30		9
10	Interest and Other Investment Income	(6,340)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties		21		18
19	Entertainment	0	20		19
20	Contributions	(964)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(2,075)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	1,850	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (132,558)		\$	30

OHF USE ONLY

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(476,126)	SCHED	34
35	Other- Attach Schedule	0	TACHED	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (476,126)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (608,684)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb BURNHAM HEALTHCARE

0043398 Report Period Beginning:

01/01/2000

Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
A. General Services														
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	149	0	0	0	0	0	0	0	149	5
6	Maintenance	1,850	0	4,217	1,406	0	0	0	0	0	0	0	7,473	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1,850	0	4,217	1,555	0	0	0	0	0	0	0	7,622	8
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	2,515	0	0	0	0	0	0	0	0	2,515	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Program	0	0	2,515	0	0	0	0	0	0	0	0	2,515	16
C. General Administration														
17	Administrative	0	(536,416)	0	0	0	0	0	0	0	0	0	(536,416)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,099	31,042	139	0	0	0	0	0	0	0	32,280	19
20	Fees, Subscriptions & Promotions	(3,039)	0	597	0	0	0	0	0	0	0	0	(2,442)	20
21	Clerical & General Office Expenses	0	15,416	(21,581)	93	0	0	0	0	0	0	0	(6,072)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	164	0	0	0	0	0	0	0	0	164	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	873	418	0	0	0	0	0	0	0	0	1,291	25
26	Insurance-Prop.Liab.Malpractice	0	810	2,083	133	0	0	0	0	0	0	0	3,026	26
27	Other (specify):*	0	6,190	12,815	0	0	0	0	0	0	0	0	19,005	27
28	TOTAL General Administration	(3,039)	(512,028)	25,538	365	0	0	0	0	0	0	0	(489,164)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,189)	(512,028)	32,270	1,920	0	0	0	0	0	0	0	(479,027)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number: BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2000 Ending:

12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(125,029)	538	1,233	1,471	0	0	0	0	0	0	0	(121,787)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,340)	0	0	2,789	0	0	0	0	0	0	0	(3,551)	32
33	Real Estate Taxes	0	0	0	2,829	0	0	0	0	0	0	0	2,829	33
34	Rent-Facility & Grounds	0	0	0	(17,798)	0	0	0	0	0	0	0	(17,798)	34
35	Rent-Equipment & Vehicles	0	3,935	6,715	0	0	0	0	0	0	0	0	10,650	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(131,369)	4,473	7,948	(10,709)	0	0	0	0	0	0	0	(129,657)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(132,558)	(507,555)	40,218	(8,789)	0	0	0	0	0	0	0	(608,684)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 BOOKKEEPING FEES	\$ 80,000	EKS MANAGEMENT		\$	\$ (80,000)
16	V						
17	V	6 PAINTING SALARIES		" "		4,217	4,217
18	V	10 RN CONSULTANT SALARIES		" "		2,515	2,515
19	V	19 PROFESSIONAL FEES		" "		31,042	31,042
20	V	20 WANT ADS		" "		597	597
21	V	21 OFFICE EXPENSE		" "		58,419	58,419
22	V	23 SEMINARS		" "		164	164
23	V	25 TRANSPORTATION		" "		418	418
24	V	26 INSURANCE		" "		2,083	2,083
25	V	27 EMPLOYEE BENEFITS		" "		12,815	12,815
26	V	30 DEPRECIATION		" "		1,233	1,233
27	V	35 EQUIPMENT RENT		" "		6,715	6,715
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 80,000			\$ 120,218	\$ * 40,218

Sum_6A

-80000

4217

2515

31042

597

58419

164

418

2083

12815

1233

6715

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6B

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 OFFICE RENT	\$ 17,798	IME REALTY CORP.		\$	\$ (17,798)
16	V						
17	V	5 UTILITIES		" "		149	149
18	V	6 REPAIRS & MAINTENANCE		" "		1,406	1,406
19	V	19 PROFESSIONAL FEES		" "		139	139
20	V	21 OFFICE EXPENSE		" "		93	93
21	V	26 INSURANCE		" "		133	133
22	V	30 DEPRECIATION		" "		1,471	1,471
23	V	32 INTEREST		" "		2,789	2,789
24	V	33 RE TAX		" "		2,829	2,829
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 17,798			\$ 9,009	\$ * (8,789)

Sum_6B

-17798

149

1406

139

93

133

1471

2789

2829

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginn 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6D

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8			
						Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			Schedule V. Line & Column Reference	
							Hours	Percent	Description				Amount
1	MORRIS ESFORMES		MANAGEMEN	38.00				mnmnt fees	\$ 33,584	17-8	1		
2	PHILIP ESFORMES		MANAGEMEN	19.00					0		2		
3	NACHSON DRAIMAN			38.00							3		
4	MICHAEL ROSEN	ADMINISTRATOR		5.00				SALARY	122,307	17-1	4		
5											5		
6											6		
7											7		
8											8		
9											9		
10											10		
11											11		
12											12		
13								TOTAL	\$ 155,891		13		

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST RE

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number **BURNHAM HEALTHCARE**# **0043398** Report Period Beginning: **01/01/2000**Ending: **1/31/2000**

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization **EMI ENTERPRISES**Street Address **3737 W. ARTHUR**City / State / Zip Code **LINCOLNWOOD, IL 60712**Phone Number **(847) 674-1946**Fax Number **(847) 674-1962**

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	OFFICERS SALARY	PATIENT DAYS	617,052	11	\$ 185,000	\$ 185,000	112,018	\$ 33,584	1
2	19	ACCOUNTING FEES	PATIENT DAYS	617,052	11	6,053		112,018	1,099	2
3	21	OFFICE EXPENSE	PATIENT DAYS	617,052	11	84,917	64,123	112,018	15,416	3
4	25	TRANSPORTATION	PATIENT DAYS	617,052	11	4,810		112,018	873	4
5	26	INSURANCE	PATIENT DAYS	617,052	11	4,462		112,018	810	5
6	27	EMPLOYEE INSURANCE	PATIENT DAYS	617,052	11	34,099		112,018	6,190	6
7	30	DEPRECIATION	PATIENT DAYS	617,052	11	2,964		112,018	538	7
8	35	AUTO LEASE	PATIENT DAYS	617,052	11	21,677		112,018	3,935	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 343,982	\$ 249,123		\$ 62,445	25

Print Preview

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization EKS MGMT.Street Address 3737 W. ARTHURCity / State / Zip Code LINCOLNWOOD, IL 60712Phone Number (847) 674-1946Fax Number (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING SALARIES	PATIENT DAYS	617,052	11	\$ 23,229	\$ 23,229	112,018	\$ 4,217	1
2	10	RN CONSULTANT SALARY	PATIENT DAYS	617,052	11	13,856	13,856	112,018	2,515	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	617,052	11	170,994	131,341	112,018	31,042	3
4	20	WANT ADS	PATIENT DAYS	617,052	11	3,290		112,018	597	4
5	21	OFFICE EXPENSE	PATIENT DAYS	617,052	11	321,801	269,147	112,018	58,419	5
6	23	SEMINARS	PATIENT DAYS	617,052	11	905		112,018	164	6
7	25	TRANSPORTATION	PATIENT DAYS	617,052	11	2,302		112,018	418	7
8	26	INSURANCE	PATIENT DAYS	617,052	11	11,476		112,018	2,083	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	617,052	11	70,589		112,018	12,815	9
10	30	DEPRECIATION	PATIENT DAYS	617,052	11	6,797		112,018	1,233	10
11	35	EQUIPMENT RENT	PATIENT DAYS	617,052	11	36,988		112,018	6,715	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 662,227	\$ 437,573		\$ 120,218	25

Facility Name & ID Number **BURNHAM HEALTHCARE**# **0043398** Report Period Beginning: **01/01/2000**Ending: **12/31/2000**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization **IME REALTY CORP**Street Address **3737 W. ARTHUR**City / State / Zip Code **LINCOLNWOOD, IL 60712**Phone Number **(847) 674-1946**Fax Number **(847) 674-1962**

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	100	11	\$ 1,685	\$	9	\$ 149	1
2	6	REPAIRS & MAINTENANCE	INCOME	100	11	15,902		9	1,406	2
3	19	PROFESSIONAL FEES	INCOME	100	11	1,575		9	139	3
4	21	OFFICE EXPENSE	INCOME	100	11	1,047		9	93	4
5	26	INSURANCE	INCOME	100	11	1,504		9	133	5
6	30	DEPRECIATION	INCOME	100	11	16,647		9	1,471	6
7	32	INTEREST	INCOME	100	11	31,549		9	2,789	7
8	33	RE TAX	INCOME	100	11	32,000		9	2,829	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 101,909	\$		\$ 9,009	25

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	CORUS BANK		X	MORTGAGE	INTEREST	2/26/98	\$ 15,100,000	\$ 0		0.0775	\$ 435,200	1	
2	COLE TAYLOR		X	MORTGAGE	\$172,076.55	05/24/00	15,700,000	15,653,430	06/01/05	0.0875	845,527	2	
3												3	
4												4	
5												5	
	Working Capital												
6	CORUS BANK		X	WORKING CAPITAL	INTEREST	03/01/99	500,000	0		0.0825	70,706	6	
7												7	
8												8	
9	TOTAL Facility Related				\$172,076.55		\$ 31,300,000	\$ 15,653,430			\$ 1,351,433	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 31,300,000	\$ 15,653,430			\$ 1,351,433	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Print Preview

Facility Name & ID Number **BURNHAM HEALTHCARE**# **0043398** Report Period Beginning: **01/01/2000** Ending: **12/31/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	516,010	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	577,666	2
3. Under or (over) accrual (line 2 minus line 1).	\$	61,656	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	577,666	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	639,322	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	0	8
	1996	0	9
	1997	505,388	10
	1998	516,010	11
	1999	577,666	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATIC \$	16

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,554 B. General Construction Type: Exterior 3 STORY Frame BRICK Number of Stories 3

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO

If so, please complete the following:

1. Total Amount Incurred:	0	2. Number of Years Over Which it is Being Amortized:
---------------------------	---	--

3. Current Period Amortization: 0 **4. Dates Incurred:** _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		0	1998	\$ 1,500,000	1
2					2
3	TOTALS	0		\$ 1,500,000	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Page 12

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	309		1998		\$ 12,649,700	\$ 324,351	39	\$ 324,351	\$	\$ 905,480	4
5											5
6											6
7											7
8				IME ALLOCATION							8
9	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	ROOF		1998		74,000	1,898	39	1,898		4,824	9
10	WALLCOVERINGS		1998		39,379	1,009	39	1,009		2,565	10
11	PAINTING		1998		12,962	333	39	333		846	11
12	WINDOW TREATMENTS		1998		38,112	977	39	977		2,483	12
13	FENCE		1998		650	17	39	17		43	13
14	NEW WINDOWS		1998		20,445	524	39	524		1,332	14
15	PAINTER'S SALARIES		1998		64,064	1,643	39	1,643		4,176	15
16	NURSE STATION		1998		23,100	592	39	592		1,505	16
17	TILING		1998		635	16	39	16		41	17
18	BUILT IN CABINTRY		1998		64,700	1,659	39	1,659		4,094	18
19	NEW COILS FOR AHV		1999		6,000	154	39	154		237	19
20	NEW BOILER		1999		20,328	521	39	521		803	20
21	HOT WATER TANK		1999		2,750	71	39	71		109	21
22	ROOF		1999		29,500	756	39	756		1,166	22
23	PATIO		1999		5,080	339	15	339		522	23
24	AWNING		1999		3,000	200	15	200		308	24
25	LIGHTS		1999		7,603	195	39	195		301	25
26	NURSE CALL SYSTEM		1999		1,957	50	39	50		77	26
27	WINDOW TREATMENTS		1999		11,207	287	39	287		443	27
28	CORRIDOR BORDERS		1999		6,154	158	39	158		243	28
29	SCREENS		2000		3,543	70	27.5	70		70	29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 335,820		\$ 335,820	\$	\$ 931,668	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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01/01/2000(Ending: 12/31/2000

Facility Name & ID Numbe BURNHAM HEALTHCARE

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Facility Name & ID Numbe BURNHAM HEALTHCARE

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Facility Name & ID Numbe BURNHAM HEALTHCARE

0043398

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number **BURNHAM HEALTHCARE**# **0043398**Report Period Beginning: **01/01/2000** Ending: **12/31/2000****XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componer Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 1,377,848	\$ 257,452	\$ 137,785	\$ (119,667)	10 YRS	\$ 329,825	37
38	Current Year Purchases	56,079	8,166	2,804	(5,362)	10 YRS	2,804	38
39	Fully Depreciated Assets							39
40	RELATED PARTY		3,242	3,242				40
41	TOTALS	\$ 1,433,927	\$ 268,860	\$ 143,831	\$ (125,029)		\$ 332,629	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 604,680	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 479,651	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (125,029)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,264,297	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO16. Rental Amount for movable equipm: \$ **20,401** Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	1998 BMW	\$ 750.00	\$ 8,500	17
18	NURSING	1998 BLAZER	440.00	5,280	18
19	FACILITY	1999 DIDGE RAM	417.00	3,756	19
20					20
21	TOTAL		\$ #####	\$ 17,536	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2001 \$ _____

13. _____/2002 \$ _____

14. _____/2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p style="text-align: right;"> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO </p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY TRAINED AIDES.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number BURNHAM HEALTHCARE# 0043398 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 150,689	\$		\$ 150,689	1
2	Licensed Speech and Language Development Therapist		hrs			50,515			50,515	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			133,226			133,226	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				74,751		74,751	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					12,406	51,134		63,540	13
14	TOTAL			\$		\$ 346,836	\$ 125,885		\$ 472,721	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 483,933	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,429,478		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	298,668		6
7	Other Prepaid Expenses	349,864		7
8	Accounts Receivable (owners or related parties)	273,199		8
9	Other(specify): RE ESCROW	129,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,964,142	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500,000		13
14	Buildings, at Historical Cost	12,649,700		14
15	Leasehold Improvements, at Historical Cost	435,169		15
16	Equipment, at Historical Cost	1,433,927		16
17	Accumulated Depreciation (book methods)	(1,674,520)		17
18	Deferred Charges	237,205		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(27,674)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 14,553,807	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 18,517,949	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 306,450	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	217,248		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,029		31
32	Accrued Real Estate Taxes(Sch.IX-B)	577,666		32
33	Accrued Interest Payable	117,639		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	495,838		36
37	Due to Lessor/Prior Owner	245,489		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,990,359	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	15,653,430		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 15,653,430	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 17,643,789	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 874,160	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 18,517,949	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (29,744)	1
2	Restatements (describe):		2
3	STATE REPLACEMENT TAX	(10,175)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (39,919)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,690,829	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(776,750)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 914,079	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 874,160	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,039,403	1
2	Discounts and Allowances for all Levels	9,156	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,048,559	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	164,448	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 164,448	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**	6,340	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,340	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,219,347	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	\$ 1,483,073	31
32	Health Care	3,476,724	32
33	General Administration	2,236,851	33
	B. Capital Expense		
34	Ownership	2,675,602	34
	C. Ancillary Expense		
35	Special Cost Centers	472,721	35
36	Provider Participation Fee	183,547	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,528,518	40
41	Income before Income Taxes (line 30 minus line 40)**	1,690,829	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus	\$ 1,690,829	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1 Director of Nursing	4,160	4,367	\$ 124,247	\$ 28.45	1
2 Assistant Director of Nursing					2
3 Registered Nurses	39,385	41,991	845,689	20.14	3
4 Licensed Practical Nurses	32,276	34,211	525,482	15.36	4
5 Nurse Aides & Orderlies	155,717	163,016	1,255,224	7.70	5
6 Nurse Aide Trainees					6
7 Licensed Therapist					7
8 Rehab/Therapy Aides					8
9 Activity Director					9
10 Activity Assistants	17,348	18,157	109,812	6.05	10
11 Social Service Workers	17,260	18,356	165,752	9.03	11
12 Dietician					12
13 Food Service Supervisor					13
14 Head Cook					14
15 Cook Helpers/Assistants	33,499	35,978	246,826	6.86	15
16 Dishwashers					16
17 Maintenance Workers	15,331	15,938	144,099	9.04	17
18 Housekeepers	30,352	32,615	206,391	6.33	18
19 Laundry	18,148	19,297	116,355	6.03	19
20 Administrator	2,400	2,445	133,637	54.66	20
21 Assistant Administrator					21
22 Other Administrative					22
23 Office Manager	2,080	2,152	50,274	23.36	23
24 Clerical	13,391	13,869	161,098	11.62	24
25 Vocational Instruction					25
26 Academic Instruction					26
27 Medical Director					27
28 Qualified MR Prof. (QMRP)					28
29 Resident Services Coordinator					29
30 Habilitation Aides (DD Homes)					30
31 Medical Records	8,461	8,857	64,234	7.25	31
32 Other Health Care(specify)					32
33 Other(specify)	13,346	14,242	164,424	11.55	33
34 TOTAL (lines 1 - 33)	403,154	425,491	\$ 4,313,544 *	\$ 10.14	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35 Dietary Consultant	M	\$ 18,935	1-3	35
36 Medical Director	O	7,000	9-3	36
37 Medical Records Consultant	N	4,268	10-3	37
38 Nurse Consultant	T	0	10-3	38
39 Pharmacist Consultant	H	5,580	10-3	39
40 Physical Therapy Consultant	L	0	10a-3	40
41 Occupational Therapy Consultant	Y	0	10a-3	41
42 Respiratory Therapy Consultant		4,250	10a-3	42
43 Speech Therapy Consultant		0	10a-3	43
44 Activity Consultant	F	3,900	11-3	44
45 Social Service Consultant	E	3,725	12-3	45
46 Other(specify)	E			46
47 PSYCHO-SOCIAL CONSULT	S	0	10-3	47
48				48
49 TOTAL (lines 35 - 48)		\$ 47,658		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50 Registered Nurses		\$	10-3	50
51 Licensed Practical Nurses			10-3	51
52 Nurse Aides			10-3	52
53 TOTAL (lines 50 - 52)		\$		53

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATI	1998	\$ 3,683	3 YRS	\$	\$ 614	\$ 1,228	\$ 1,228	\$ 613	\$	\$	\$	\$
2	PAINT/DECORATI	1999	1,866	3 YRS			311	622	622	311			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 5,549		\$	\$ 614	\$ 1,539	\$ 1,850	\$ 1,235	\$ 311	\$	\$	\$

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